Approved Date: January 13, 2010
Revised Date(s): April 14, 2010
June 15, 2011
April 11, 2012

CRITERIA FOR PRIOR AUTHORIZATION

Rituximab (Rituxan®)

PROVIDER GROUP: Professional

MANUAL GUIDELINES: The following drug requires prior authorization:
Rituximab (Rituxan®)

CRITERIA for non-Hodgkin's lymphoma (NHL) or chronic lymphocytic leukemia (CLL): (must meet all of the following)

- Patient must be 18 years of age or older
- Patient must have a diagnosis of non-Hodgkin's lymphoma or chronic lymphocytic leukemia
- Must be prescribed by an oncologist or hematologist

CRITERIA for rheumatoid arthritis (RA): (must meet all of the following)

- Patient must be 18 years of age or older
- Patient must have a diagnosis of moderate to severe, active rheumatoid arthritis
- Must be prescribed by a rheumatologist
- Must be given in combination with methotrexate
- Must have documentation of inadequate response to one or more TNF antagonist therapies
- Evaluation for latent tuberculosis infection with TB skin test prior to initial PA
- Patient has not taken another biologic agent (see table) in the past 30 days

CRITERIA for Wegener's granulomatosis (WG) and microscopic polyangiitis (MPA): (must meet all of the following)

- Patient must be 18 years of age or older
- Patient must have a diagnosis of Wegener's granulomatosis or microscopic polyangiitis
- Must be taken in combination with glucocorticoids

RENEWAL CRITERIA for ALL indications: (must meet initial prior authorization criteria in addition to the following)

- Documentation of appropriate lab testing (CBC and platelets)
    - In patients with lymphoid malignancies:
        - using Rituxan monotherapy monitor labs prior to each Rituxan course
        - using Rituxan and chemotherapy monitor labs at least monthly
    - In patients with RA, WG, or MPA monitor labs every 2-4 months

Warnings: This drug carries a Black Box Warning. Fatal infusion reactions, tumor lysis syndrome (TLS), severe mucocutaneous reactions, and progressive multifocal leukoencephalopathy (PML) may occur. The duration of cytopenias caused by rituximab can extend months beyond the treatment period.

Prior Authorization will be approved for six (6) months.

Biologic Agents

Generic Name	Brand Name
Abatacept	Orencia®
Adalimumab	Humira®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Infliximab	Remicade®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Tocilizumab	Actemra®
Ustekinumab	Stelara®